HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

AHC Media

MARCH 2017 Vol. 25, No. 3; p. 29-44

Does Discharging a Patient Make You Feel Like You're Herding Cats?

Multidisciplinary rounds can help end the chaos

When patients are ready to be discharged from your hospital, is everyone scrambling to get orders filled and post-acute care lined up while the patient and family members fume because they can't leave yet?

Do you spend a good part of your day fielding phone calls from other members of the treatment team, answering the same questions from several members of the team, and trying to reach physicians with questions?

Does the treatment team at your hospital rely so heavily on communicating through the electronic medical record that they rarely have actual face-to-face conversations about their patients?

When the team does get together, is the meeting disorganized and

EXECUTIVE SUMMARY

Multidisciplinary rounds that bring together the entire treatment team and, often, patients and family members, are a key in relieving the chaos that often occurs on the day of discharge.

- The rounds increase communication and promote collaboration around the discipline by keeping everyone on the treatment team on the same page.
- Rounds save time for case managers because they hear every discipline's plans for their patients at the same time and everyone on the team avoids fielding multiple phone calls during the day.
- Rounds should be carefully planned and strictly scripted with a strong facilitator to keep everyone on the subject and ensure that the rounds are short and productive.
- Participants should include physicians, case managers, nurses, social workers, pharmacists, therapists, and, on occasion, support staff such as chaplains.

Financial Disclosure: Editor **Jill Drachenberg**, Ebook Design Specialist **Dana Spector**, and Contributing Editor **Mary Booth Thomas**, report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Nurse Planner **Toni Cesta**, PhD, RN, FAAN, Consulting Editor of Hospital Case Management, is a consultant with Case Management Concepts LLC.

HOSPITAL CASE MANAGEMENT

Hospital Case Management™,
ISSN 1087-0652, is published monthly by
AHC Media, LLC
One Atlanta Plaza
950 East Paces Ferry Road NE, Suite 2850
Atlanta, GA 30326.
Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to:
Hospital Case Management
P.O. Box 550669
Atlanta, GA 30355.

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421.
Customer.Service@AHCMedia.com.
AHCMedia.com
Hours of operation: 8:30 a.m.- 6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

SUBSCRIPTION PRICES:
U.S.A., Print: 1 year (12 issues) with free Nursing Contact Hours or CMCC clock hours, $519. Add $19.99 for shipping & handling. Online only, single user: 1 year with free Nursing Contact Hours or CMCC clock hours, $469.

Outside U.S., add $30 per year, total prepaid in U.S. funds.

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Back issues: $78. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date.
GST Registration Number: R128870672.

ACCREDITATION: Relias Learning, LLC, is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Contact hours [1.25] will be awarded to participants who meet the criteria for successful completion. California Board of Registered Nursing, Provider CEP#13791.

This activity has been approved by the Commission for Case Manager Certification for 18 clock hours.
The target audience for Hospital Case Management™ is hospital-based case managers. This activity is valid 24 months from the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

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excruciatingly long, with little structure and little follow-up?

These scenarios may sound familiar to case managers at many hospitals, but they can be avoided if the entire treatment team gets together daily for a well-organized and short discussion of every patient they are responsible for, experts say.

The activities may be called "interdisciplinary rounds" or "multidisciplinary rounds" and the structure and participants may vary from hospital to hospital, but the purpose is to improve patient care and throughput by facilitating communication among team members.

"In the era of bundled payments and other value-based reimbursement programs, hospitals need better care coordination and lower costs. Interdisciplinary rounds are a no-cost strategy for improving care coordination at the bedside," says **Toni Cesta**, RN, PhD, FAAN, partner and consultant in North Bellmore, NY-based Case Management Concepts.

Change-of-shift rounds, teaching rounds, patient care conferences, and huddles are all important but should not be a substitute for interdisciplinary rounds, Cesta says.

"Interdisciplinary rounds are an opportunity to engage the entire healthcare team," she adds.

In many hospitals, workflow is extremely fragmented with dozens of holes, resulting in disjointed and uneven delivery of care, says **Tony Gorski**, managing director in the healthcare business at Huron Consulting Group, and co-founder and chief executive officer of MyRounding, a firm specializing in digital health solutions.

As a result, the activities that take place during the last 48 hours of the typical patient stay often are "controlled chaos," Gorski says. "It's like trying to herd cats or catch a pig. Everything is happening at the last minute and a lot of things fall through the cracks as the team struggles to get the patient out the door," he says.

"For instance, the physician may need the results of a test before signing the discharge order, and everybody has to race to make the patient a priority. But often, the need for the test could have been anticipated at admission or early in the stay and discussed during multidisciplinary rounds, avoiding the last-minute scramble," Gorski says.

Medication issues are sometimes responsible for delayed discharges when medications are prescribed at the last minute, Gorski says.

"There's not usually a streamlined process to fill prescriptions quickly, and the nurses have to rush through the instructions on how to take medication. This causes anxiety and lack of patient satisfaction," he says.

When the multidisciplinary teams meet every day and collaborate on carrying out what it takes to get the patient discharged on a given date, it eliminates the last-minute holdups, Gorski adds.

The Joint Commission and the Institute for Healthcare Improvement both consider interdisciplinary walking rounds a best practice, Cesta points out.

But despite this, many hospitals don't have the rounds, or they implement them sporadically or half-heartedly, Gorski says. *(For tips on how to organize the rounds, see related article on page 31.)*

"Interdisciplinary rounds are a best practice, but I'm surprised by how many hospitals I visit that don't have them. I don't know how you can provide exceptional patient care unless everyone on the team communicates," adds **Jean Maslan**, BSN, MHA, ACM, senior managing consultant for Berkeley Research Group,

headquartered in Emeryville, CA.

Stefani Daniels, RN, MSNA, CMAC, ACM, founder and managing partner of Phoenix Medical Management, a Pompano Beach, FL, hospital case management advisory firm, reports that in her consultations with hospitals across the country, she has seen efforts at creating interdisciplinary team coordination with varying success. Daily huddles and walking rounds have been successful at some hospitals, but many clinicians struggle with interdisciplinary communication, she adds.

"I don't see interdisciplinary coordination like I would hope to see. Many times, there's just a bunch of people sitting around and talking about discharge planning. This not an interdisciplinary approach to providing the best care," Daniels adds.

One problem is that hospital culture is not geared for the process of interdisciplinary collaboration, and many hospitals don't have a way of fixing any glitches that impede patient flow, Gorski says. "Most hospitals have broken processes, and even though they have excellent people providing care for the patients, when the process is broken, they get average results," Gorski says.

Gorski points out that process engineers in other settings spend their days fixing problems that affect the workflow, but it doesn't happen at hospitals. "Ask leadership at the average acute care hospital how many processes have been changed to fix a broken patient flow problem, and they don't know because hospital staff members don't think that way," Gorski says.

Multidisciplinary rounds are an opportunity for the team to work together to identify and fix the problems, he adds. When everyone who is caring for a patient gets together every day and talks through delivery of care for the patient, it can reduce readmissions, cut length of stay, and increase patient satisfaction, Gorski says. *(For information on who should attend the rounds and where they should be held, see article on page 32.)*

"If hospitals aren't having daily interdisciplinary rounds that enable team members to communicate with each other on a daily basis, they're missing a chance to move patients efficiently and effectively through the continuum," Maslan says.

When the team stays on top of what's going on with the patient every day, it can have a huge effect on length of stay, patient satisfaction, and readmission reduction, Maslan says. "If everybody is on the same page, discharge orders won't be a big surprise and the staff won't have to scramble to get everything done at the last minute," she adds.

But it's more than just improving length of stay and the bottom line, she adds. "Interdisciplinary rounds improve quality by putting everyone on the team on the same page and making sure the right things are done at the right time," Maslan says.

Interdisciplinary walking rounds provide a real-time, in-person exchange of information on the goals and plan of care for the patient among all members of the team as well as the patient and family, Cesta says.

The rounds are an important tool for case managers because they hear the plan for all their patients in a small amount of time, rather than having to track down physicians and nurses during the day, Cesta says. By improving communication and teamwork and reducing duplication, the rounds can improve patient flow and help case managers anticipate discharge needs and expedite a smooth transition, she adds. ■

Interdisciplinary Rounds Must be Short and Well Organized

Disjointed, lengthy meetings discourage attendance

Interdisciplinary rounds must be quick and orderly — otherwise, key members of the team won't join in, says **Jean Maslan**, BSN, MHA, CCM, ACM, senior managing consultant for Berkeley Research Group, with headquarters in Emeryville, CA. You need to develop a formal plan, she adds.

The structure for the rounds has to be carefully laid out and the rounds themselves must be well-thought out, Maslan says. The rounds won't be effective if your team decides to have them one day and skip the next day, she adds.

Toni Cesta, RN, PhD, FAAN, partner and consultant in North Bellmore, NY-based Case Management Concepts, recommends that hospital leadership appoint a committee to create a formal plan for rounds based on how the process will work best in each individual hospital.

The committee should start by identifying the goals for the rounds, and then creating a structure for the rounds. Develop a short, simple tool with standardized questions to guide the rounds.

Develop key talking points for each discipline, create a plan for assigning responsibility for follow-up items, and designate someone to make sure the items are completed, Maslan advises.

Scripting is very important for rounds to be productive, Cesta points out. "One of the biggest reasons that attempts at interdisciplinary rounds fail is that participants don't stay on the subject, the rounds take too long, and people drift away," she says.

Interdisciplinary rounds need a strong facilitator to keep the team on the subject, Maslan adds. "Someone has to keep the team on track and ensure that they are respectful of everybody's time. If there are a lot of extraneous conversations and people don't find them worthwhile, they will stop coming," she says.

In addition, to be effective, the idea of interdisciplinary rounds must be championed by senior hospital management and hardwired into the treatment team's daily routine, Cesta says. The rounds should be held every day and attendance must be mandatory, she adds.

The rounds should focus on the plan of care, expected outcomes of care, barriers to care, transitions within levels of care in the hospital, and discharge, Cesta says. Review the patient's current status, clarify the patient and family's long-term goals and desired outcomes, and create a comprehensive plan of care. Set a daily goal for each patient and write it down. Identify any safety risks and the need for patient and/or family education.

The case manager should discuss the expected length of stay, the status of the discharge plan, any barriers to discharge, or reimbursement issues, Cesta says.

Explain what medical milestones the patient needs to reach for discharge, and what details in the discharge plan need to be completed, Maslan adds.

"Because advocacy is the care manager's primary ethical obligation, multidisciplinary rounds are the best venue to discuss resource utilization and make sure the team avoids placing the patient/family in any clinical or financial risk," says **Stefani Daniels**, RN, MSNA, CMAC, ACM, founder and managing partner of Phoenix Medical Management, a Pompano Beach, FL, hospital case management advisory firm.

Discuss whether the test or procedure being ordered by the physician is appropriate for this patient, and whether it reflects the patient's or family members' preference, Daniels advises. Is it excessive, wasteful, duplicative, or potentially harmful? Does the patient have the resources to pay for it?

"Not only is this a 'best practice' for care coordination, it also helps team members start thinking in terms of patient advocacy," Daniels adds.

Keep a list of tasks to be completed, and follow up, Cesta says.

Rounds should last no longer than one to two minutes per patient, Maslan says. "If the team doesn't have a structure, the rounds will last a long time. Clinicians are so busy. If they don't find the rounds helpful, they'll find reasons not to show up and a key member of the team will be missing," she says.

Don't forget to review your progress, Cesta advises. Outcomes to measure include reduction in length of stay, reduction in ICU stays, lower morbidity and mortality, and increase in patient and staff satisfaction. ■

The Who, Where, and How of Rounding Makes a Big Difference

The biggest challenge in establishing multidisciplinary rounds is getting everybody on the team to participate, says **Tony Gorski**, managing director of healthcare business at Huron Consulting Group.

"Nurses, case managers, social workers, and ancillary staff all work for the hospital, so it's fairly easy to get them to participate. The challenge is to get the meetings to fit into the physicians' schedules," he says.

However, if the rounds are well planned and focused, most physicians will welcome them because they save time and eliminate multiple phone calls, he adds.

"Without multidisciplinary rounds, the physician may be contacted by nursing, social work, and the pharmacy individually regarding patient needs. It's disparate, fragmented, and extremely frustrating," Gorski says.

Disciplines involved in multidisciplinary rounds vary according to the patients, but typically include the

core nursing staff, the case management team including social work, representatives from the finance and pharmacy departments, and the attending physician, Gorski says.

If the hospital doesn't have hospitalists and community physicians are not interested in participating, the rest of the interdisciplinary team should round anyway, says **Toni Cesta**, RN, PhD, FAAN, partner and consultant in North Bellmore, NY-based Case Management Concepts.

She suggests inviting support staff, such as pastoral care or palliative care representatives, to participate one or two times a week.

"It is a best practice for the physicians to participate. It puts the entire team on the same page because they know the plan the physician has in mind, and what his or her parameters are for patient discharge," says **Jean Maslan**, BSN, MHA, ACM, senior managing consultant for Emeryville, CA-based Berkeley Research Group.

But the challenge is to fit it into the physicians' schedules, she adds.

To increase efficiency, Gorski recommends that physicians, nurses, case managers, and other staff be assigned by unit or floor.

Hospitalists are one of the big variables in multidisciplinary rounds because they often see patients in multiple units on multiple floors, points out **Stefani Daniels**, RN, MSNA, CMAC, ACM, founder and managing partner of Phoenix Medical Management, a Pompano Beach, FL, hospital case management advisory firm.

Daniels advocates "regionalization" of hospitalists — assigning them by unit or by service line — so they will work with the same team to provide care for the same group of patients and be accountable for their care. "This gives hospital leadership an opportunity to create a care team that includes a physician who is caring for a particular group of patients and is working closely with a care manager, a social worker, a pharmacist, a nurse manager, and other appropriate disciplines to provide consistent care for a patient population," Daniels says.

Pharmacists can be a valuable participant in rounds, Maslan points out. They can provide input on the medication the patient is taking, or suggest a cheaper substitute for a discharge medication if the patient may not be able to afford the one prescribed.

Be flexible when you schedule the rounds, Maslan suggests. There usually aren't enough physical therapists or pharmacists to attend rounds on every floor if they are held at the same time, she points out. "Many times, the case manager, social worker, and nurse can attend, but if rounding times aren't staggered unit-to-unit, the team runs the risk of not having a physical therapist or pharmacist present," she says.

Another solution might be to assign staff to the units where their expertise is most needed. For instance, physical therapists are essential for rounds on an orthopedic unit, and it would be beneficial to have a pharmacist present for interdisciplinary rounds in the ICU.

Walking rounds that include the case manager, nurse manager, pharmacist, and hospitalists and rounds in the patients' room during shift change are popular with patients because it gives them a chance to participate in their care plan, Daniels reports. The rounds are an opportunity for all the key players, including hospitalists, to discuss the patients and each member of the team to their priorities for the day, she says.

Have the rounds in the patient room, alert patients in advance of the time they will take place, and invite them and their family members to participate, Cesta says. During the rounds, encourage patients to add input and ask questions, she adds. Tell the patients you will come back after rounds if they have a lot of questions.

"We encourage the family to be present so they will be involved in the plan, and they love it because they get a chance to ask questions and be involved. When family members are present, it improves satisfaction for everybody," Cesta says.

Structured interdisciplinary bedside rounds (SIBR) bring patients and family members into the discussion, Gorski says. *(For details on one hospital's SIBR initiative, see related article on page 34.)*

"The only way to get patients out the door faster and safely is to get them involved in the discussion about their own healthcare," he says.

Healthcare providers aren't going to make SIBR work perfectly in the first 30 days, Gorski says. "Staff have to be trained to train the patient to participate. Many patients are afraid to ask questions when the doctor comes in the room. The goal of SIBR is to take that wall away and include the patient in planning the care," he says.

Based on her experience as a consultant, Maslan recommends holding rounds in a conference room, especially on medical-surgical units, rather than walking from patient room to patient room. "In working with hospitals, I've found that it is more efficient to hold the rounds in a room. With walking rounds, you have a whole group of people in front of the patient and family, and it's difficult to get everything accomplished in a few minutes. The rounds end up taking a couple of hours and valuable team members start to fall off in attendance," she says. ■

Making Patients Part of the Team Helps Hospital Cut LOS, Boost HCAHPS Scores

Interdisciplinary rounds bring care planning to the bedside

After Emory Saint Joseph's Hospital in Atlanta began holding interdisciplinary rounds at the bedside and encouraging patients and family members to participate, length of stay dropped, patient satisfaction increased, and patient safety issues decreased on the units where the pilot was implemented.

Emory Saint Joseph's piloted the Structured Interdisciplinary Bedside Rounds (SIBR) process on two units in 2014 and added two additional units last year.

SIBR process was developed by a team of clinicians and lay advisors at Emory Healthcare in 2010 as part of the health system's Care Transformation initiative aimed at providing patient-and-family-centered care.

"SIBR moves the plan of care to the bedside and involves the patient and family members. We don't talk about the patient with each other — we talk to the patients and family members and make them part of the team," says **Ginger Parks**, MSN, RN, NEA-BC, unit director of Pulmonary and Internal Medicine at the 410-bed acute care hospital.

The bedside rounds are part of Emory Saint Joseph's Accountable Care Unit model, Parks says. "It's one component of the total package of relationships between providers and patients. Our goal is to make sure that the patient becomes a central part of the care and that all providers are on the same page," Parks adds.

The rounds are held at the same time every day, and typically last about an hour, or three-to-five minutes per patient, Parks says. They are strictly structured and follow a specific script. The unit charge nurse is the rounds manager and keeps a list of issues that need follow-up, and makes sure the follow-up is completed.

Participants include the physician, the nurse, the case manager, a pharmacist, and any other discipline providing care for the patient. For instance, a respiratory therapist attends rounds on the pulmonary unit. Family members are encouraged to participate in the rounds and are present about 75% of the time, Parks says. "If the family isn't there, the physician calls them after rounds and gives them an update," she says.

"SIBR puts the patient at the center of the plan and enables them to see their care process in a different way. Having the entire team together in the same room minimizes miscommunication, identifies gaps in care, and helps us avoid errors," she says.

The physician opens the conversation by introducing the team and giving an update on the patient's condition and treatment plan. Each team member also provides the patient and family an update, and asks for their input. The team develops a plan for the day and talks about details of the discharge plan.

The pharmacist brings a workstation on wheels so that medication orders can be entered into the medical record at the moment they are issued. "The nurse is aware that medication has been ordered and can make sure it arrives on the unit and that the patient gets it in a timely manner," Parks says.

The team goes over a checklist for safety issues filled out by the night shift nurses as they evaluate the patients. The list notes if patients have a Foley catheter, a central line, venous thromboembolism prevention, skin integrity issues, hypo- and/or hyperglycemia, and that applicable core measures have been completed. The night nurse also notes the insertion date of any device, vital signs, intake and output, mental status, and any concerns.

"The best way to prevent a device-

EXECUTIVE SUMMARY

Length of stay dropped and patient satisfaction rose when Emory Saint Joseph's Hospital in Atlanta began holding Structured Interdisciplinary Bedside Rounds (SIBR).

- The rounds are held daily, last about an hour, and are attended by physicians, nurses, case managers, pharmacists, and other disciplines providing care for the patients.
- As team members discuss the patient's condition, the care plan, and discharge needs, they encourage the patient and family to give their input.
- Initially, the team members were concerned about finding the time for the rounds, but they report the rounds save time by bringing the team together and eliminating phone calls and trying to track other clinicians down.

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

How to Improve the Quality of Case Management Departments through Staffing, Part 2

By Toni Cesta, PhD, RN, FAAN

Introduction

Last time, we reviewed the roles and functions of the RN case manager and the social worker in today's contemporary case management models. As we discussed, standardization is key to the success of any case management department. Budgets are tight these days and, while there are standard roles and functions for any department, there are ways in which the department also can be creative and thoughtful in designing additional roles that may better meet the needs of your hospital as well as the population of patients you serve.

This month, we will discuss some new and creative ways to use the staffing within a case management department, but let's be clear: You still need to have the foundational positions discussed last time. The creative elements come in when you need to address other issues or needs within the department. The goal is to optimize the resources you have at hand and to think outside the box whenever you need.

THE GOAL IS TO OPTIMIZE THE RESOURCES YOU HAVE AT HAND AND TO THINK OUTSIDE THE BOX WHENEVER YOU NEED.

Once you have established your foundational positions, including the roles and functions associated with them, you can begin to identify where gaps may be located. You may need to shift resources in order to adequately manage the workload and to achieve the expected outcomes of the department. Ask yourself the following questions:

- Do I have a clear demarcation as to who does what?
- Do I have the resources in the right places?
- Do I need specialized roles to support the foundational positions?
- Have I adequately covered my entry routes to the hospital?
- Do I have a large number of long-stay patients?
- Do I have a large surgical service, including ambulatory and inpatient surgeries?
- Is my transitional process for patients as tight as it could be?
- Do I need an in-house physician advisor?
- Is my leadership team adequate to meet the needs of the department?
- Does my health system have community-based case management?
- Do you have trouble keeping your staff up to date on regulatory and other issues?
- Do you have difficulty orienting and managing new hires?

If the answer to any of these questions is yes, then you may want to consider one or more of the following positions. Even if you haven't answered yes to any of these questions, you may still have identified an area of opportunity for your department. Each position carries pros and cons. The most significant con is always the cost of the position weighed against the value added by the position.

Access Point Case Manager

Within the role of access point case manager are two distinct roles: the ED case manager, and the admitting department case manager. Let's review each of these positions so you can evaluate whether you need to have one or more of these in your department.

The ED case manager and the admitting department case manager positions are in the category we will call access point case management. These positions are designed to manage and control the types of patients and the levels

of care approved for admission to the hospital. They also provide for alternative care when needed and appropriate. Through the access point case management roles, the hospital has a greater level of assurance that their patients are placed in the right level of care to ensure greater reimbursement. The admitting department case manager provides gatekeeping functions for the following types of patients:

- planned admissions,
- urgent admissions,
- direct admissions, and
- transfers.

The admitting case manager works directly with the admitting department staff to review all but emergency admissions. On some occasions, these patients may be appropriate for placement in observation rather than an admission. The admitting case manager may also see some patients during presurgical testing to begin the case management assessment process, and/or to begin the discharge planning process. These patients are usually surgical, planned admissions.

The ED case manager has responsibility for patients presenting to the ED. This position has become increasingly important with the advent of the Two-Midnight Rule via CMS, as this position plays an important gatekeeping role for emergent patients. The Two-Midnight Rule requires that patients be placed in observation if the physician anticipates the patient will not remain in the hospital for more than two midnights. On these occasions, the patient should be placed into observation. During the period of observation, the physician can gather additional information and make a determination as to whether the patient needs to be admitted to the hospital or can be discharged from observation. The ED case manager reviews patients after the physician has determined that the patient must be kept in the hospital but before a status determination is made. Through this review, as well as discussions of the plan of care with the physician, the patients can be placed in observation, admitted to the hospital, and discharged from the emergency department. This is an integral and key process needed to maintain compliance with the Two-Midnight Rule and to reduce the level of denials for Medicare patients.

In addition to this important function, the ED case manager is responsible for coordinating and facilitating patient flow in the ED by ensuring that tests, treatments, procedures, or consults are performed in a timely manner. This process helps to manage length of stay in the ED and to expedite discharges when appropriate. When transitioning home from the ED, the case manager can prepare a discharge plan that meets the patient's needs, including the possibility of home care. This process can reduce the number of inappropriate and unnecessary hospital admissions. The ED case manager may also begin and/or complete the clinical review process in sending information to a third-party payer. If not completed in the ED, this function helps reduce the workload for the unit-based case manager. Finally, the ED case manager may work with the ED physician to reduce overutilization of resources such as tests, treatments, consults, or procedures.

If your hospital admits less than 60% of your patients via the ED, you may want to consider a shared role if the budget does not allow for both positions. If more than 60% of your admissions enter via the ED, you should seriously consider having both positions. In other words, depending on the routes of entry, ED and admitting might be a shared role if smaller numbers are admitted via the ED, or two roles if greater numbers of patients are admitted through the ED.

Perioperative CM

If your hospital has a significant surgical program (at least 20 inpatient beds), then you should consider the perioperative case manager position. Depending on the volume of ambulatory surgical patients in your hospital, this position might manage these patients as well. The position is responsible for patients as they transition from preadmission testing until discharge from the post-anesthesia care unit (PACU). It is during this process, as well as before, that the case manager continuously ensures the patient is in the right status postoperatively such as extended recovery, observation, or inpatient admission. The perioperative case manager provides clinical coordination and transitional planning across the continuum of the patient's surgical or perioperative process. This position works to identify and remove barriers that might prevent or slow the patient's progress through the perioperative phase of care. This would include identification of barriers during the preoperative process as well, particularly those that might result in cancellation or delay of the surgical procedure.

The periop case manager coordinates care in concert with physicians, nurses, patients, and families, ensuring a smooth and safe movement through the periop process, including discharge from the PACU. The case manager may make referrals to home health, sub-acute, or acute rehabilitation as needed, providing pertinent information to these post-acute providers. Finally, the periop case manager should provide a report to the next case manager, ensuring the handoff communication includes a verbal, as well as written, process.

Transfer Center CM

The transfer center case manager is responsible for transfers into and out of the hospital. You may want to consider this position if your hospital conducts a large number of transfers in or out of the hospital. If you do not perform a lot of transfers, you may want to consider combining this position with the admitting department case manager. Let's begin with a discussion of the management of the transfers into the hospital. The transfer center case manager reviews patients for medical necessity, including both the level of care and the status, for any patient transferred into the hospital for any of the following areas:

- inpatient acute care,
- inpatient rehabilitative care,
- long-term acute care, and
- skilled nursing facility.

The person in this position must have a working knowledge of EMTALA rules and regulations so patients transferred from outlying hospital EDs are handled appropriately and legally. They serve as a liaison between sending hospitals and case managers on the accepting hospital's units for communication regarding medical necessity and any communication between transfer center case manager and accepting physician. They ensure there is authorization for any patient transferred in who is out of network (unless EMTALA applies). They work to facilitate a timely acceptance of patients transferred into the hospital, and work with the admitting department to identify any non-EMTALA patients to ensure that there has been an accurate assessment of benefits.

When time allows, the transfer case manager may review any documents from sending hospitals. When possible, this should include uploading the patient record so the transfer center case manager can review the record and perform the initial review of medical necessity while the patient is transferred. Finally, for any patient that is on the transfer waiting list, the case manager should review documents to assess medical necessity and any potential discharge planning needs.

For transfers out of the hospital, the case managers coordinate applicable EMTALA rules and regulations. They review required state forms for appropriate completion. They ensure authorizations for any payer requiring this, usually for higher level of care or services not provided in hospital. Finally, they participate in any collegial discussions with hospitals or other entities transferring to your system's facilities.

Complex Discharge Planning Specialist

If your hospital has at least 15 to 20 patients on any given day who require intense and complex discharge planning, then you may want to consider this position. While the complex discharge planning specialist can be a social worker or RN, the position is usually filled with a social worker experienced in managing difficult-to-discharge patients. The purpose of this position is to free up the staff case managers and social workers from these time-consuming patients, and have the patients' discharge planning needs managed by a specialist who works intensely on these patients.

The focus for the position can be patients who have exceeded a predetermined length of stay threshold, or it can be patients whose discharge planning needs are so intensive that they may divert the staff from managing and moving the more routine patients. The patients are assigned to the specialist who continues to work with the nurse case manager as a dyad.

Physician Advisor

The physician advisor has become a must-have for most case management departments. While some hospitals have opted to outsource this function, many continue to retain an in-house physician advisor. The physician in this position can be full-time or part-time, depending on the needs of your department. The physician supports the clinical review function of the case management department regarding the medical necessity of patients. He or she may meet with case management and healthcare team members to discuss selected cases, and may be called on to address specific attending physician issues when there are delays in throughput or discharge, or when there is a discrepancy in the ordered status of a patient. This role has become particularly important in supporting compliance to the Two-Midnight Rule. The physician advisor may chair the utilization review committee and support resource utilization and other issues around length-of-stay management. Many of these functions are difficult to perform via an outsourced process.

Community CM

The acute care case manager can no longer work in isolation, disconnected from community-based providers. For some patients, this may mean connecting these patients to a case manager who will assist in managing their care outside the hospital setting. Based in a community setting such as a patient-centered medical home or clinic, the community case manager follows clinically high-risk patients who score high on a risk stratification scale. Patients selected for case management in the commu-

nity may be those who have a chronic condition that places them at risk for poor clinical outcomes, visits to the ED, or readmission to the hospital. They work with patients, doctors, and nurses involved with patient care to promote adherence to the medical care plan.

When necessary, the RN case manager will deploy a community outreach worker to provide home- or community-based support to further enhance the patient's compliance to the medical care plan (e.g., assistance getting to/from appointments, obtaining medications from pharmacy, etc.), or engage patients who do not respond to contact attempts.

Other roles for the community case manager include use of the patient registry to monitor patients' compliance with medical and lab appointments, and reach out to remind patients of upcoming appointments. When appointments are missed, the RN case manager will assist with rescheduling and maintaining future appointments.

Social Work Community Case Manager

The social worker follows psychosocially complex behavioral health or substance abuse patients who may also be followed by the RN community case manager for their clinical needs.

He or she works with patients and various community providers, as determined by the patient's psychosocial needs, to address nonmedical needs that may impede adherence to the medical care plan.

Like the RN case manager in the community, when necessary, the social worker will deploy a community outreach worker to provide home- and/or community-based support to further enhance the patient's compliance to the medical care plan, or engage patients who do not respond to contact attempts.

Transitions CM

The transitions case manager can be an important role in the management and reduction of hospital readmissions. As CMS continues to add conditions to the readmission penalty list, a position of this type will increasingly become important to hospitals that continue to have high readmissions. The transitions case manager follows high-risk patients while in the hospital and during the first 30 to 90 days after discharge, depending on complexity and adherence to the medical plan. The patients are followed telephonically with linkages to primary care providers, home care, and others as needed. Their focus may be on frequent readmissions as well as specific diagnoses, particularly chronic conditions.

Director of Case Management

The following titles for the case management department leadership may need to be adapted to the titles in your organization. The director is the highest-level leadership positon in the department and is responsible for the day-to-day operations of the department including hiring and firing, budget, staffing, and evaluations. The director is expected to monitor the department's outcomes through maintenance of a case management report card or dashboard. The director reports to a senior leader in the organization.

Manager of Case Management

The manager of case management is the second in command and is in charge of the department in the director's absence. He or she serves as the direct report for the staff and assists with performance evaluations. The manager also maintains correct staffing ratios on a daily basis.

Educator of Case Management

If your department is having trouble keeping staff current on new regulations, and/or orientation and precepting new staff, you may want to consider this position. The educator is responsible for orientation of new staff in concert with unit-based preceptors and evaluates the orientees, provides monthly educational updates to staff and leadership, and provides education related to departmental software as needed.

Supervisor of Case Management

Depending on the size of your department, you may need to have a supervisor who reports to the manager of the department. The supervisor provides day-to-day support to the manager and may occasionally take an assignment.

Our final role is that of the team leader. This is a staff RN or social worker leader who has a patient assignment and provides mentoring and/or preceptorship to staff. This position can be used as a career ladder opportunity for staff as well.

Summary

The titles listed above should provide you with some ideas for creative staffing for your own department. Remember to think about your gaps and be creative as you explore new options. ■

related infection is to remove the device as quickly as possible. The safety checklist ensures that we have a conversation every day about whether the device is still needed," she says.

After the rounds, the case manager, the physician, and the nurse review all of the discharges anticipated for the day to make sure everything is in place.

Case managers find the rounds particularly beneficial, Parks says. "The case manager gets a good idea of the physician's plan for the patient, the family's perception of the patient's needs, any roadblocks to discharge, and other information needed to facilitate a smooth transition," she says.

Since the rounds began, the length-of-stay index (the ratio of actual to expected length of stay) on the two units in the pilot dropped to 0.92 and 0.86, Parks reports. The two units, which treat mostly geriatric and complex patients with multiple comorbidities, have had only one patient who developed a central line infection and one patient with a catheter-associated urinary tract infection over a two-year period.

The average score on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) increased 16 points from fiscal 2015 to fiscal 2016 on the units, Parks adds.

Parks attributes the drop in length of stay to eliminating gaps in care. "In the past, we would think we were ready to discharge a patient, but would find out on the last day that something was preventing discharge. Now the team share information and we identify any roadblocks earlier," she says.

When the SIBR was rolled out, the biggest concern among participants was how to carve out time for the rounds, but now the team members see the rounds as a way to share information more efficiently, Parks says.

"Before these rounds, the team had multiple, duplicative conversations and phone calls throughout the day to get the same information they gathered during the rounds. By rounding at the bedside, we've increased efficiency, and the time we've gained on the back end is greater than the time we spend on rounds," she says.

Team members go through formal and internal education about the rounds and can become SIBR certified by completing a course of study. Certified staff train new employees and observe them to ensure that they are following the process.

Before implementing SIBR, the team at Emory Saint Joseph's held tabletop rounds in a room.

"We're still refining the process. As healthcare changes, we have to be adaptable and move people through the system faster than in the past. Patients have more complex needs than ever before, which means that preparing people to transition to the next level of care is increasingly important," Parks says. ■

Care Management Revamp Helps Keep Readmission Rates Low

Seamless program ensures smooth handoffs

Flagstaff (AZ) Medical Center hasn't had a readmission penalty for four years, and consistently has an all-cause readmission rate for Medicare patients of 12%, compared to a statewide average of 16% and a national rate of 18.6%.

Following a challenge from the chief medical officer to cut the heart failure readmission rate in half, Flagstaff Medical Center, Northern Arizona Healthcare's flagship hospital, reduced its all-cause 30-day readmissions from 23% to 12% by assigning patient care managers to stay in touch with at-risk patients through phone calls and telemedicine, says **Lisa Brugh**, MS, BSN, RN, ACM, system director of care management for Northern Arizona Healthcare.

That was in 2013. The next year, the care management leadership added pneumonia, myocardial infarction, chronic obstructive pulmonary disease, and total joint replacements to the program and staffed it with additional care managers. The program has also expanded to the system's other hospital, Verde Valley Medical Center in Cottonwood, which has an all-cause Medicare 30-day readmission rate of 10.8%.

Flagstaff Medical Center is a major regional referral center and treats patients from a wide area, much of which is rural. "We are the only Level 1 trauma center in the northern part of the state and we're often on deferral. We try to put patients in beds only if they need to be there and focus on moving patients through the continuum as quickly as possible and

making sure they have what they need to prevent an unnecessary readmission," Brugh says.

As part of the initiative to focus on transitions of care, a multidisciplinary team was trained on the Project BOOST (Better Outcomes by Optimizing Safe Transitions, developed by the Society of Hospital Medicine) program for preventing readmissions. The inpatient care coordinators and other treatment team members use Project Boost's 8P tool to identify risk factors that could lead to readmissions. The health system's electronic medical record includes a care management module and a readmission module, which automated the 8P data so the care coordinators could quickly identify patients who were at risk and implement appropriate interventions.

The care management department staff has developed a seamless program to meet the post-acute needs of all patients with staff who follow the high-risk patients through the continuum, Brugh reports.

The inpatient care coordinators assess patients in the hospital and refer the at-risk patients to the outpatient team. Care management assistants work with the inpatient care coordinators to implement the discharge plan. They set up follow-up appointments, arrange for durable medical equipment deliveries, and take care of other discharge needs.

"They handle the groundwork to get patients discharged so the care coordinators don't have to spend a lot of time on the telephone or doing paperwork," Brugh says.

The outpatient team, located in a medical office building on the hospital campus, includes a call center, RN care managers, social workers, and health coaches.

When the outpatient team gets a referral, an RN care manager visits the patient in the hospital, completes an evaluation using a risk adjustment tool, and develops a follow-up plan.

Depending on the diagnosis and the patient's risk score, the care manager may suggest a telemedicine program, one or more home visits by a coach, telephonic interventions, visits by a paramedic in the community, or home health visits.

The outpatient care managers identify patients that could benefit from telemedicine and set it up while the patient is still in the hospital. They get the patients to sign the consent forms, provide them with the equipment, and teach them how to use it. The patients receive monitoring equipment such as scales, thermometers, oximeters, and transmit their metrics to the care management department every day.

The outpatient team's health coaches work with patients who need extra education and help understanding and following their treatment plans. The coaches are patient care techs or medical assistants and are trained to make home visits, if needed, for additional follow-up.

Nurses in the outpatient care management department call every inpatient, observation patient, and high-risk ED patient shortly after discharge to review the discharge instructions, identify patients who didn't get their medication or who didn't understand their discharge instructions, and refer patients who need extra help to the care managers for follow-up.

Care coordinators, either nurses or social workers, cover the ED 24/7 and assess patients as they come in. A team of utilization review nurses also staff the ED seven days a week from 8 a.m. to midnight to serve as a resource when the physicians determine patient admission status. If patients do not meet criteria for an inpatient admission or observation services, the utilization review nurses refer them to the ED care coordinators to develop a safe discharge plan.

"The emergency department care coordinators can line up acute rehabilitation, facilitate a hospice consultation, or set up home health services and prevent a readmission," Brugh says.

The care coordinators are alerted when a patient is readmitted within 30 days so they can assess the patient

EXECUTIVE SUMMARY

Thanks to a series of initiatives to focus on at-risk patients after discharge, Flagstaff Medical Center has avoided readmission penalties for four years and consistently has a 12% all-cause Medicare readmission rate.

- Inpatient care coordinators assess patients in the hospital and refer those who are at risk to the outpatient care management team, which visits the patients in the hospital and determines the appropriate post-discharge interventions.
- Depending on their risk scores, patients may receive home visits from coaches, telephone calls from care managers, telemedicine monitoring, or a combination of interventions after discharge.
- Care coordinators who staff the ED 24/7 set up services including home health, skilled nursing transfers, hospice consults, and other interventions, when appropriate, to prevent a readmission. Utilization review nurses are a resource with physicians when they determine patient status.

and revise the discharge plan and try to find out why the discharge plan failed. A team of care management staff performs a root cause analysis on every patient who is readmitted and presents the results to the hospital leadership.

"More changes are in the planning stage," Brugh adds. She and her team are developing a post-acute resource center by moving FTEs from the care coordination positions to the resource center. The center will include case management assistants who will work with the inpatient care coordinators setting up equipment deliveries, making referrals to home health agencies and skilled nursing facilities, and other tasks that do not require a license.

By taking on the non-clinical tasks, the case management assistants will free up the inpatient care coordinators to work closely with the physicians and nurses to develop a progression of care plan, Brugh says. Once a progression of care plan is approved, the care coordinators will hand it over to the resource center staff.

The post-acute resource center includes care coordinators and may also include a social worker and nurses to handle whatever situations require their expertise. The center will be a resource for the bedside nurses who handle simpler discharges, for the outpatient surgery nurses, and the ED, as well as the inpatient care coordinators, she says.

"We are getting ready for the new discharge planning Conditions of Participation to go into effect. Since the proposed changes may require a discharge plan for every inpatient, observation patient, and outpatient, we're taking a proactive approach with our resource center. The only alternative would be to locate care coordinators all over the hospital," Brugh says. ■

Hospitals Can Now Factor Socioeconomic Status into Readmissions

Hospitals have long complained that assessments of readmission rates do not take into account the socioeconomic factors that can influence them, resulting in facilities serving the neediest patients taking a financial hit when they don't meet national standards. That is about to change with the introduction of a law that allows hospitals to factor in that information when determining readmission rates.

Some hospital leaders will rejoice, but there is concern that the law will result in some facilities lowering the bar for acceptable readmission rates.

The change comes as a detail in the 994 pages of the 21st Century Cures Act, which was signed into law in December 2016. The law originated to address biomedical innovation but became a catch-all for a variety of healthcare issues, including a provision that requires Medicare to account for patient backgrounds when determining financial penalties under the Hospital Readmissions Reduction Program. Hospitals are penalized if a patient returns to the hospital within 30 days after discharge for the same reason they were originally admitted.

Readmissions at hospitals serving a high proportion of disadvantaged patients can be higher because discharged patients have limited access to food, medication, and follow-up care. A rate higher than the national average results in CMS reducing Medicare reimbursement.

The new law will redistribute the penalties across a greater number of hospitals, says **Neil Smiley**, CEO at Loopback Analytics, a healthcare consulting group based in Dallas. That means there will be winners and losers.

"Folks that thought they were in great shape and not subject to any readmission penalties are likely to have a rude awakening as risk gets redistributed from hospitals that have a high dual-eligible population to those that don't," Smiley says. "Those that have been really struggling with readmissions may be able to sit back and realize it's no longer as much of a problem."

Inner-city hospitals and those with a high teaching component have been most unfairly affected the penalties, so they are likely to benefit the most. More affluent hospitals will find their target for readmissions has suddenly been lowered, requiring steps to stay below the national average, he says.

"The law is revenue-neutral, so it's not like the penalties are lessened," Smiley explains. "The amount of money CMS takes back is going to be the same. It's just going to come from different players."

Bar Could Be Lowered

There is some controversy over the law, with critics saying that reducing penalties to safety net hospitals with

a disadvantaged population amounts to letting those hospitals meet a lower standard of care than others, condemning that population to a lower quality of care than more affluent patients. There is a danger of hospitals letting their readmissions efforts slip because the threat of penalty is not as much, Smiley says.

"One of the very perverse aspects of the readmission penalties is that they encourage hospital CFOs to shoot for mediocrity," Smiley says. "If you're any better at reducing readmissions it costs you money, and if you're any worse it costs you money. Mediocrity is where you have optimal financial returns with these penalties. What you want to be is spot-on average, no worse and no better, which seems kind of crazy to me."

The effects of the law should be felt immediately as hospitals calculate readmissions and determine where they stand under the new law. Actual financial repercussions will take longer, as the readmissions program has a three-year tail for calculating averages.

"People will do their calculations and figure whether they're still in the penalty soup or not," Smiley says. "Those who have invested in trying to reduce readmissions may ask whether they need to double down, and others may ask if they can let off the pedal a little bit and reinvest those resources somewhere else."

Bundled payments would be a better alternative, encouraging quality without penalizing hospitals unfairly, says **Donald Fry**, MD, executive vice president for clinic outcomes management with MPA Healthcare Solutions in Chicago, and adjunct professor of surgery at Northwestern University Feinberg School of Medicine. Fry notes that factors such as income levels, employment, geographic location from the index hospital, and a caregiver in the patient's home need to be considered in the payment structure, and in the likelihood that patients will seek ED or readmission care.

Bundled payment strategies can do this with appropriate databases and could eliminate the Medicare Hospital Readmissions Reduction Program in its entirety, Fry says.

Fry also notes that there can be a problem with defining safety net hospitals. Some facilities thought of as safety net hospitals have substantial financial reserves from well-insured patients, he says.

"Waiving the readmission reduction penalties based on the amount of unreimbursed care that some providers may be giving a pass to some very solvent and well-to-do facilities," Fry says. "Medicare patients, even if they are going to safety net hospitals, are not the charity care patients that many of us have spent lifetimes taking care of. They are not the down-and-out, unemployed, indigent patients that have nothing else in the world. So when we look at waiving readmission penalties on well-insured patients, I'm having a hard time understanding why that's a good thing." ■

Healthcare Workers Don't Mind Masking to Protect Patients

Viral infections fall dramatically in stem cell patients

A universal masking policy for healthcare providers and home care workers dramatically reduced respiratory viral infections in hematopoietic stem cell transplant (HSCT) patients, researchers report.[1]

Routine required mask use has been associated with some pushback in some instances, particularly when used as a policy for healthcare workers who decline flu shots. However, in this case, healthcare workers were on board with enthusiasm once they understood the risk to a vulnerable patient population.

"Everyone was very compliant and they realized the importance of the issue," says **Mitchell E. Horwitz**, MD, associate professor of medicine and director of the Clinical Research Adult Blood and Marrow Transplant Program at Duke University Medical Center in Durham, NC. "These are not N95 [respirators] and uncomfortable. They are surgical masks and much easier to tolerate. Anecdotally, the head nurse believes there were fewer respiratory infections among nursing staff because they were wearing masks more frequently and there were less infections being passed from nurse to nurse."

Parainfluenza virus 3 (PIV3) — the primary threat to this particular patient group — was reduced sharply from an infection rate of 8.3% to 2.2% following the mask intervention.

"That really is the virus that was most prevalent in our population and causing the most symptoms," he says. "Influenza and respiratory syncytial

virus are much more serious, but fortunately, not as common. Whether [this intervention] would help reduce those viruses is not clear because of the relatively low numbers, but the parainfluenza was the biggest [factor] and was really the impetus for the study."

The surgical mask policy requires all workers in inpatient and outpatient HSCT facilities with direct patient contact to wear surgical masks regardless of symptoms or season. While standard infection control procedures are effective against respiratory infections, they may be insufficient to prevent the spread of PIV3. That is because providers and others with PIV3 may shed virus while asymptomatic, Horwitz explains.

Thus, standard droplet precautions that focus on symptomatic patients (or workers) may not be protective. Similarly, strategies that increase infection control measures during the winter influenza and respiratory syncytial virus (RSV) seasons neglect PIV3, which peaks in the summer months, he notes.

The Duke stem cell unit was hit hard with respiratory infections in 2009, leading to the creation of the new policy: All healthcare workers and caregivers of HSCT must wear a surgical mask around the patients. The masking policy was in effect year-round.

The researchers compared the infection rate from the period of 2003-2009 to the post-intervention timeframe of 2010-2014. Overall, respiratory infections dropped from a rate of 10.3% in the no-mask period to 4.4% after the policy. Significant decreases were seen for both allogeneic and autologous transplants. Again, infections due to PIV3 comprised the majority of the reduced infections.

The findings suggest that the asymptomatic workers may have spread viral infections to patients prior to the masking policy.

"Yes, that is certainly true, and it also was true of the [home] caregivers that were involved with the patient management," Horowitz says. "When someone is going through a bone marrow transplant, at least in our program, they spend a lot of time out of the hospital. So by instituting this not only by healthcare providers, but by caregivers at home, I think that is how we were able to have this impact." ■

REFERENCE

1. Sung AD, Sun J, Thomas S, et al. Universal Mask Usage for Reduction of Respiratory Viral Infections After Stem Cell Transplant: A Prospective Trial. *Clin Infect Dis* 2016; 63(8):999-1006.

Readmission Rates for Bariatric Surgery Drop with QI

Thirty-day readmission rates for bariatric surgery patients can be reduced by implementing a series of quality improvement efforts, according to recent research. Some of the top performers in the study more than doubled the average readmission reduction.

The American Society for Metabolic and Bariatric Surgery (ASMBS) and The Obesity Society (TOS) reported recently on research presented at the groups' annual meeting and highlighted a study led by **John M. Morton**, MD, director of bariatric surgery at Stanford Hospital & Clinics in California. The study involved the Decreasing Readmissions through Opportunities Provided (DROP) program, part of the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP), a joint program of the American College of Surgeons (ACS) and the ASMBS.

A significant portion of bariatric surgery readmissions are preventable, stemming from issues such as nausea and vomiting, or nutritional problems including electrolyte depletion, ASMBS reports. DROP was implemented at 128 facilities performing bariatric surgery that in the prior year had an average readmission rate of 4.79%. Six months later, the readmission rates dropped an average of 14%, but the top performers in the study saw reductions of 32%.

The DROP program focuses on quality improvement measures that address the most common causes of bariatric readmissions with improved nutrition counseling, discharge processes, psychological therapy, and other methods. ■

COMING IN FUTURE MONTHS

- What's new with the Recovery Auditors?
- Discharge planning for hard-to-place patients
- How to accommodate your patient's cultural beliefs
- How your peers are improving transitions

HOSPITAL
CASE MANAGEMENT

CME/CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.
2. Log on to AHCMedia.com, then select My Account to take a post-test.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the test, a credit letter will be emailed to you instantly.
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CME/CE QUESTIONS

1. **According to says Toni Cesta, RN, PhD, FAAN, partner and consultant in Case Management Concepts, interdisciplinary walking rounds are considered to be a best practice by the Joint Commission and the Institute for Healthcare Improvement.**

   A. True
   B. False

2. **According to Jean Maslan, BSN, MHA, CCM, ACM, managing consultant for Berkeley Research Group, how long should the team spend discussing each patient during multidisciplinary rounds?**

   A. No longer than five minutes.
   B. No longer than one or two minutes.
   C. Three to four minutes.
   D. Depends on the patient's condition and other issues.

3. **A team at Emory Saint Joseph's Hospital in Atlanta holds Structured Interdisciplinary Bedside Rounds (SIBR) each day. Who is the rounds manager who keeps a list of items that need follow-up?**

   A. The unit charge nurse.
   B. The case manager.
   C. The hospitalist.
   D. Depends on the patient population.

4. **What hours do the care coordinators at Flagstaff Medical Center cover the ED?**

   A. 8 a.m. to 8 p.m. every day.
   B. 8 a.m to 8 p.m. weekdays and 9 a.m. to 5 p.m. weekends.
   C. 24 hours a day, seven days a week.
   D. 24 hours a day on weekdays, and 8 a.m. to midnight on weekends.

CME/CE OBJECTIVES

After reading each issue of *Hospital Case Management*, the nurse will be able to do the following:

1. identify the particular clinical, administrative or regulatory issues related to the profession of case management
2. describe how the clinical, administrative or regulatory issues particular to the profession of case management affect patients, case managers, hospitals or the healthcare industry at large
3. discuss solutions to the problems facing case managers based on independent recommendations from clinicians at individual institutions or other authorities.